Mount Auburn Hospital

Supplemental Life & Long Term Disability Insurance Enrollment Form

1. Name (please print) ANTHONY P.. SCAPICCHIO, M.D.

Social Security number 024 - 28 - 8555 Scheduled hours 40

Effective date of coverage ___/___/___ (to be completed by Benefits Department)

2a. I hereby elect the following supplemental life insurance coverage:

Supplemental Life at: MAH provides-base $400,000.00

___ 1X or ___ 2X or X 3X my annual base pay additional Supplemental 400,000.00

Beneficiary(ies) designation: ANTHONY P. SCAPICCHIO IRREVOCABLE INSURANCE TRUST TIN# 04-6738234

Primary: Name_____ Relationship_____ %____

Name_____ Relationship_____ %____

Contingent: Name_____ Relationship_____ %____

Name_____ Relationship_____ %____

2b. I hereby elect the following dependent life insurance coverage:

Dependent Life:

___ Option 1 ($10,000 for spouse; $3,000 per dependent child over 6 months, $500 for 8 day-6 months)

X Option 2 ($25,000 for spouse; $5,000 per dependent child over 6 months, $500 for 8 day-6 months)

I REQUEST THE ABOVE INDICATED BENEFITS FOR THE FOLLOWING DEPENDENTS:

Name	Relationship	Date of birth	Social Security #	Student Status
DIANA SCAPICCHIO	SPOUSE	JULY 8,1942	028-30-3653	N/A
SARAH SCAPICCHIO	DAUGHTER	JULY 6,1976	028-54-5703	FT college student: YX N__
				FT college student: Y__ N__

Beneficiary for Dependent Life if other than yourself: _____

3. I hereby elect the following optional long term disability coverage:

For full-time (40 hour) employees only:

Supplemental Long Term Disability

___ Option 1 (90 day waiting period instead of 180 days with basic plan)

X Option 2 (90 day waiting period instead of 180 days with basic plan, 70% of monthly pay instead of 60% with basic plan & annual cost of living increases)

For 30-39 hour employees only:

___ Part-time Long Term Disability (180 day waiting period, 60% of monthly pay, & $11,000/month maximum)

I understand my deduction for any supplemental Life or LTD Insurance coverage will change whenever there is a change in my base pay or age category.

I have completed the worksheet and/or reviewed the rates for the above selections. I hereby authorize Mount Auburn Hospital to deduct the cost of these plans from my pay.

Anthony P. Scapicchio — Signature

6 September 1994 — Date